Massachusetts Hospital Association Claims Update
August 7, 2008

Recipient **E**ligibility **V**erification **S**ystem**:**

The Division of Health Care Finance and Policy has identified an issue where Commonwealth Care (Comm Care) eligible but unenrolled individuals are noted in REVS as having HSN eligibility. Comm Care eligible but unenrolled individuals are eligible for HSN 10 days prior to their date of application and 90 days after their application date or until the date in which they are covered by Comm Care. If an individual does not enroll with Comm Care before the 90 day period ends, they lose their HSN eligibility as of the 91st day after the date of application. If the individual enrolls in Comm Care in the future, they are eligible for HSN from the date in which their premium payment is received by Comm Care to their date of Comm Care coverage.

The Division has identified instances where REVS is displaying that an individual is eligible for HSN for the period of time from the 91st day of the application date and the date in which they enroll in Comm Care and their payment is received by the Connector. The Division has notified MassHealth of this issue as individuals are not eligible for HSN during this period of time and submitted claims will be denied.

The following example highlights this process and the applicable periods of HSN eligibility.

> John Smith applied for Comm Care on July 1, 2008. Mr. Smith has HSN eligibility from the period of 10 days prior to the date of application (June 21) up to 90 days after the date of application (September 29) or the date in which Mr. Smith is covered by Comm Care. As of September 30, 2008, Mr. Smith has not enrolled in Comm Care and is no longer eligible for HSN. On November 19, 2008, Mr. Smith enrolls with Comm Care and his premium payment is received by Comm Care on November 26. Mr. Smith would be covered by Comm Care as of January 1, 2009 and would be eligible for HSN from November 26 to December 31, 2008. Mr. Smith would not be eligible for HSN for the period of September 30 to November 25, 2008.

Using the example above, providers conducting a REVS check on December 2 for a date of service on November 22 are receiving a message that the individual is eligible for HSN. Submitted claims in this example would be denied as the individual is not eligible for HSN.

The Division apologizes for any inconvenience caused and has notified MassHealth of this issue. If you have any questions regarding this notice, please contact the Division's Help Desk at (800) 609-7232 or at dhcfphelpdesk@state.ma.us.

Claims Edits:

- Present on Admission indicator – As of October 1, 2008, the Division, as Medicare currently does, will be requiring the POA indicator for inpatient claims (Type of Bill 111, 117, 118.) This requirement would pertain only to 837 claims.
- DRG errors - Currently, if an inpatient claim is ungroupable, an edit warning is issued. Effective 9/1/2008, these DRG errors will result in a fatal error and cause the claim to fail. With the specifications change, providers should submit what they perceive the DRG to be as this will assist in addressing DRG errors that occur due to date of service crossovers.

- Inpatient MD services - Hospitals may submit inpatient physician services on the 837P. The Division will begin paying for these services under the Medicare fee schedule effective 1/1/2009.
- Inpatient Psych Claims - Providers should begin identifying their Inpatient Psych Claims with the appropriate Psych NPI. Providers can use the NM1 Segment with NM101 = FA and NM109 = Psych NPI in Loop 2310E (Provides the Service Facility Data) that is at the Claim Level. With claims coming in with this information, they can be Grouped/Priced as an Acute (for analysis) and processed for a Per Diem rate.

Claims Tracking:

To enable providers to view the status of their claims submission on an ongoing basis, the Division has created a HSN Claims Tracking function on INET. Deployment of this function on INET is scheduled for August 18, 2008. The Claims Tracking function allows providers to see all of the claims they have submitted to the Division, on a line by line basis, as well as the current status of the claim relative to its being denied or approved. Upon logging on to INET, providers should follow the same procedure followed to upload to / download reports from the Division. After selecting the upload / download link, providers will see the HSN Claims Tracking option.

Once the Claims Tracking option is selected, providers will see the main screen listing the following claim information:

TCN
Claim Format (UB or 837)
Date of Service
Net Charges
Total Charges

Providers can click on the TCN number to obtain further information on a claims status. Searches for specific claims can also be processed via the filter option located above the claims summary. Providers will continue to receive monthly remit and denial reports via INET as they currently do.

Providers with any questions regarding this notice should contact the Division's Help Desk at (800) 609-7232. Providers with questions regarding their 837-I claim submissions (test or production) should contact the Division's Claims Customer Support Center at (866) 697-6080.